**Extension for Community Healthcare Outcomes**

**Dementia**

**teleECHO™ Clinic Case Presentation Form**

Complete ALL ITEMS on this form and fax to 505-272-6906.

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<tr>
<td>1. Patient First Name:</td>
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<td>2. Patient Last Name:</td>
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<td>3. Patient Birthday: (month/day/year)</td>
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<td>4. Patient Gender:</td>
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<td>5. Clinician Phone Number:</td>
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<td>6. Clinician Fax Number:</td>
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<td>7. Clinician Email:</td>
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<td>8. Clinic/Facility Name:</td>
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<td>9. Clinic/Facility City:</td>
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When do you want to present your case? Date and approximate time?

*When we receive your case, we will email or fax you a confidential patient ID number (ECHO ID) that must be utilized when identifying your patient during clinic.*

**PLEASE NOTE** that Project ECHO® case consultations do *not* create or otherwise establish a provider-patient relationship between any UNMHS clinical care team and any patient whose case is being presented in a Project ECHO® setting.
Dementia TeleECHO
Clinic
— CASE PRESENTATION FORM —

GENERAL INFORMATION

Date: ____________ Presenter: ____________________________ Clinical Site: ____________

Patient Name: ________________________________________ ECHO ID: ____________

Age: _______ DOB: ________________ Gender: □ Male or □ Female

Check One: □ New Case or □ Follow-up Molina patient? □ Yes □ No

Occupation: __________________________ Educational Level ________________

WHAT IS YOUR MAIN QUESTION ABOUT THIS PATIENT?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Check all that apply (or relate to your main question) and fill in specifics:

□ Specific symptom management (insomnia, wandering, paranoia, hallucinations, etc)

□ Dementia specific treatment options __________________________________________

□ Issues of Activities of Daily Living (ADLs) [Click here for the form]

□ Issues of Instrumental Activities of Daily Living (iADLs) [Click here for the form]

□ Determining the patient’s diagnosis __________________________________________

□ Agitation and/or aggression ________________________________________________

□ Advance care planning ______________________________________________________

□ Inappropriate behavior ______________________________________________________

□ Other(s) _________________________________________________________________

Brief History of Present Illness (may attach a recent clinic progress note): ______________

Psychiatric hospitalization: □ Yes □ No Number of times: __________________________

Current and Past Medical History (may attach a list): _______________________________

Current meds and therapies (may attach a list): _____________________________________

Meds and therapies that have been tried in the past: ________________________________

Social history: __________________________________________________________________
REVIEW OF SYSTEMS

Please check all that apply:

- Insomnia
- Wandering
- Constipation
- Incontinence
- Anxiety
- Agitation
- Depression
- Drowsiness
- Other(s)

Physical Exam - Pertinent Findings:

Cognitive Screening Exam: Please attach findings

- SLUMS [Click here for the form]
- MMSE [Click here for the form]
- MoCA [Click here for the form]
- MINI-COG [Click here for the form]

MoCA Administration and Scoring Instructions [Click here for the form]

(MoCA©) is available from http://www.parkinsons.va.gov/consortium/moca.asp

Neuropsychology Testing (may attach a report): Pertinent Labs and Imaging:

Patient’s Decision Making Capacity:

- Decisional
- Not Decisional
- Not Sure

- Other: __________________________ For non-decisional patient: decisions are made by: __________________________

Financial Concerns:

- No
- Not Sure
- Yes

Goals of Care: (What is important to the patient/family?)

__________________________________________________________

__________________________________________________________

__________________________________________________________

Any other information that you think is important:

__________________________________________________________

__________________________________________________________

__________________________________________________________

PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any UNMHSC clinician and any patient whose case is being presented in a Project ECHO® setting.

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